DEPARTMENT OF MENTAL HEALTH
POLICY/PROCEDURE

SUBJECT **MEDICARE PREPAID HEALTH CARE TREATMENT AND BILLING**	POLICY NO. **401.7**	EFFECTIVE DATE **07/01/95**	PAGE **1 of 2**
APPROVED BY: **Original signed by:** **ARETA CROWELL** Director	SUPERSEDES **N/A**	ORIGINAL ISSUE DATE **07/01/95**	DISTRIBUTION LEVEL(S) **1, 3**

PURPOSE

1.1 To provide Department of Mental Health (DMH) policy and guidelines concerning treatment and billing procedures for clients covered under Prepaid Medicare Health Care Plans.

1.1.1 DMH policies regarding Medi-Cal Prepaid Health Care Plans and Private Prepaid Health Care Plans are available as separate policies (401.6 and 401.8, respectively).

POLICY

2.1 Clients receiving Medicare benefits through managed care plans, e.g., Health Maintenance Organizations (HMO), Prepaid Health Plans (PHP), Managed Care Plans (MCP), Primary Care Physician Plans (PCPP) and Primary Care Case Management (PCCM), must first look to those entities as being responsible for the provision of their mental health services as defined by their contracted benefits.

2.1.1 If Medicare beneficiaries present themselves at a DMH directly operated clinic or contract agency, the beneficiaries should be advised that their health care plan is responsible for managing their care. Except in cases deemed “medically necessary”, the beneficiaries should be referred back to their respective plan unless the prepaid health care plan or the Medicare beneficiaries, as appropriate, are willing to pay for the full cost of their care.

2.1.2 “Medically necessary services” describes an emergent situation requiring immediate treatment. A service is “medically necessary” when it is reasonable and necessary to prevent significant illness, or to alleviate severe pain. (W&I Code 14059.5)

OVERVIEW

3.1 Prepaid health care plans serve a diverse population, including Medi-Cal, Medicare, and employer or individually paid plans.

3.2 Medi-Cal and Medicare prepaid health care plans are capitated programs in which the consumer has opted or been placed in a specific prepaid health care plan in lieu of the fee-for-service, choice of provider plan. The plan or carrier has already been paid by the government to provide both health and mental health services.

3.3 A private prepaid health care plan is an insurance plan obtained through an employer, organization, or personally by the consumer. The prepaid health care plan is paid a financial consideration by the employer, organization, or the consumer to provide health care, including mental health benefits. Many prepaid health care plans operate as both private and Medi-Cal and/or Medicare providers.

3.4 There are currently many indemnity insurance companies which offer PCPP plans. These are private insurance plans often offered at a reduced cost to the consumer, however, requiring prior authorization by the PCPP for care outside of the plan.

3.5 Effective September 1, 1993, Managed Care Plans replaced Primary Care Case Management Programs (PCCMs). Persons applying for Aid to Families with Dependent Children (AFDC) who have not already selected a primary care physician will be assigned a primary care physician under a prepaid health care plan. Persons already assigned to a PCCM will be allowed to continue with that program.

MEDICARE PREPAID HEALTH CARE PLANS

4.1 Medicare prepaid health care plans are capitated plans which have been paid to provide health services and mental health services. These plans allow for treatment of covered services outside the plan, only for “medically necessary” treatment, with prior authorization from the prepaid health care plan, or when the client chooses to personally pay for the cost of treatment.

4.2 When a Medicare prepaid health care plan denies authorization, and the consumer chooses to use the services of the Department of Mental Health or their contract providers, the consumer is responsible for the full cost of care.

COLLECTION FOLLOW UP

5.1 The Medicare prepaid health care plan is responsible for payment of the full cost of care for authorized services, and is to be billed. If routine collection efforts fail to result in payment, directly operated or County-contracted provider staff are to employ stronger methods, including, but not limited to, referral to the Treasurer-Tax Collector.

5.2 Medicare beneficiaries are responsible for payment for services solicited by them and must pay immediately following each visit. No further treatment is to be provided until each prior visit is paid for.

AUTHORITY Welfare and Institutions Code, Section 14059.5
Title 22 CCR